MDR Tracking Number: M5-04-1753-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on February 17, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the Level III office visits w/manipulation, joint mobilization, myofascial release, electrical stimulation unattended, therapeutic exercises, neuromuscular reeducation, chiropractic manipulative treatment, spinal 3-4 regions (98941), manual therapy technique from 04-08-03 through 10-30-03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 20, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
05-01-03	97014 97110 97112	No EOB	$15.00 $35.00 $35.00	1996 MFG, TWCC Rule 133.304	Review of the requestor and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA and/or EOB's reflected proof of submission. Therefore, the disputed service or services will be reviewed according to the 96 Fee Guideline. Recommend reimbursement of $15.00(97014) + $35.00(97112)= $50.00. See Rationale below for 97110.
10-27-03	97110	No EOB	$35.00		See Rationale below for 97110.
10-29-03	97110	No EOB	$35.00		See Rationale below for 97110.
10-30-03	97110	No EOB	$35.00		See Rationale below for 97110.
TOTAL		The requestor is entitled to reimbursement of $50.00			

CPT code 97110 - Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for date of service 05-01-03 in this dispute.

This Decision & Order is hereby issued this 30th day of September 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

May 4, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1753-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or

providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 43 year old female who sustained a work related injury on ___. The patient reported that while at work she was pulling a pallet full of boxes when she injured her back. X-Rays of the lumbar spine dated 5/4/02 were reported to be normal. A repeat x-ray of the lumbar spine dated 5/30/02 indicated anterior spurring at the L2, 3, and L4 levels. The patient underwent a third lumbar x-ray on 6/3/02. An MRI of the lumbar spine dated 7/29/02 was reported as normal. The diagnosis for this patient has included lumbar sprain. Treatment for this patient's condition has included physical therapy consisting of joint mobilization, chiropractic manipulation, myofascial release, therapeutic exercises, neuromuscular reeducation, and manual therapy.

Requested Services

Level III office visit w/manipulation, joint mobilization, myofascial release, electrical stimulation unattended, therapeutic exercises, neuromuscular reeducation, chiropractic manipulative treatment, spinal 3-4 regions (98941), manual therapy technique, from 4/8/03 through 10/30/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is upheld.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 43 year-old female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer indicated that the patient suffered a sprain/strain injury that was aggravated a few times during the first months of care. The ___ chiropractor reviewer noted that the patient underwent an FCE that showed she was able to do her normal job on 5/17/02 and was released to full duty work on 5/24/02, however, came off work on 5/30/02. The ___ chiropractor reviewer also noted that the patient underwent an MRI on 6/2/02 that was reported to be negative. The ___ chiropractor reviewer explained that the patient had been treated several times without any subjective or objective proof of any improvement in her pain. The ___ chiropractor reviewer also explained the only change was that the patient's pain had improved from a 5/10 to a 4/10 on 7/10/03. However, the ___ chiropractor reviewer further explained that the patient's pain level stayed the same through 10/30/03. Therefore, the ___ chiropractor consultant concluded that the Level III office visit w/manipulation, joint mobilization, myofascial release, electrical stimulation unattended, therapeutic exercises, neuromuscular reeducation, chiropractic manipulative treatment, spinal 3-4 regions (98941), manual therapy technique, from 4/8/03 through 10/30/03 were not medically necessary to treat this patient's condition.

Sincerely,